

MDR Tracking Number: M5-04-2390-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-1-04.

CPT Code 64484-WP was withdrawn by the requester on 9-24-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that fluoroscopy, supplies and materials/sterile tray and anesthesia tray, level IV established patient office visit, post-op monitoring/recovering room charges, myelography/contrast x-ray of spine and injection for nerve block on 4-24-03 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for date of service 4-24-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of September, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

June 2, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2390-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Neurology and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information from Requestor: office notes and lumbar ESI report.

Information from Respondent: FCE, radiology report and designated doctor report.

Clinical History:

This 40 year-old female claimant developed discomfort in her low back following a work-related injury on _____. The only history available regarding injury comes from designated doctor report. The claimant developed pain radiating from the low back into both lower extremities, which persisted since this injury. She underwent a series of 3 lumbar epidural steroids in March, April, and May of 2000. She underwent discectomy and fusion at L4-L5 in November of 2000. All procedures were predominantly ineffective in relieving pain.

Disputed Services:

Fluoroscopy, supplies & materials/sterile tray & anesthesia tray, level IV established patient office visit, post-op monitoring/recovery room charges, myelography/contrast x-ray of spine and injection for nerve block on 04/24/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

Nothing in the records provided for review suggest that the patient has or had a lumbosacral radiculopathy, which could or might respond to lumbar epidural steroids. The patient did not respond to any appreciable degree to total discectomy and fusion at L4-L5. She responded minimally to a previous series of lumbar epidural steroids. The patient's "pain picture" does not at all suggest lumbosacral radiculopathy. There is no definitive evidence whatsoever of lumbosacral radiculopathy.

Sincerely,